# Healthy Families Program Health Plan Fact Sheet

## 2005-06 Contract Period

**If you have any questions regarding this form, please contact Dinorah Torza at (916) 323-2072.**

Plan Name:_____

Plan contact person for follow up information: _____
(Name and phone number)

1. What types of physician specialties are offered as pediatric primary care practitioners and adolescent primary care practitioners for prospective Healthy Families Program members in your plan? (This may include nurse practitioners.)

2. Please complete the Pediatric and Adolescent Primary Care Practitioners (PCP) chart below.

| **Pediatric / Adolescent Primary Care Practitioners** | **2002** | **2003** | **2004** |
|---|---|---|---|
| Total number of PCPs in the provider network as of January 1st. | # _____ | # _____ | # _____ |
| Number of PCPs added to the provider network during the calendar year. (Indicate number and percentage.) | # _____ | # _____ | # _____ |
| | % _____ | % _____ | % _____ |
| Number of PCPs that left the provider network during the calendar year. (Indicate number and percentage.) | # _____ | # _____ | # _____ |
| | % _____ | % _____ | % _____ |
| Total number of PCPs in the provider network as of December 31st. | # _____ | # _____ | # _____ |

3. Please complete the pediatric and adolescent specialists chart below.

| **Pediatric / Adolescent Primary Care Specialists** | **2002** | **2003** | **2004** |
|---|---|---|---|
| Total number of specialists in the provider network as of January 1st. | # _____ | # _____ | # _____ |
| Number of specialists added to the provider network during the calendar year. (Indicate number and percentage.) | # _____ | # _____ | # _____ |
| | % _____ | % _____ | % _____ |
| Number of specialists that left the provider network during the calendar year. (Indicate number and percentage.) | # _____ | # _____ | # _____ |
| | % _____ | % _____ | % _____ |
| Total number of specialists in the provider network as of December 31st. | # _____ | # _____ | # _____ |

4. Please complete the Health Plan Primary Care Physician (PCP) Network Capacity Chart below. This chart requires plans to list the percentage of providers accepting new patients and the estimated number of members that the PCPs can serve by county as of January 1, 2005

| **Health Plan Primary Care Physician (PCP) Network Capacity Chart**<br><br>**Health Plan Name:**_____ | | | | |
|---|---|---|---|---|
| **COUNTY** | **Number of Pediatric & Adolescent PCPs** | **Number of Pediatric & Adolescent PCPs accepting new patients** | **Percentage of Pediatric & Adolescent PCPs accepting new patients** | **Estimated number of pediatric & adolescent patients that can be served in each county** |
| Alameda | | | | |
| Alpine | | | | |
| Amador | | | | |
| Butte | | | | |
| Calaveras | | | | |
| Colusa | | | | |
| Contra Costa | | | | |
| Del Norte | | | | |
| El Dorado | | | | |
| Fresno | | | | |
| Glenn | | | | |
| Humboldt | | | | |
| Imperial | | | | |
| Inyo | | | | |
| Kern | | | | |
| Kings | | | | |
| Lake | | | | |
| Lassen | | | | |
| Los Angeles | | | | |
| Madera | | | | |
| Marin | | | | |
| Mariposa | | | | |
| Mendocino | | | | |
| Merced | | | | |
| Modoc | | | | |
| Mono | | | | |
| Monterey | | | | |
| Napa | | | | |
| Nevada | | | | |
| Orange | | | | |
| Placer | | | | |
| Plumas | | | | |
| Riverside | | | | |
| Sacramento | | | | |
| San Benito | | | | |
| San Bernardino | | | | |
| San Diego | | | | |
| San Francisco | | | | |
| San Joaquin | | | | |
| San Luis Obispo | | | | |
| San Mateo | | | | |
| Santa Barbara | | | | |
| Santa Clara | | | | |
| Santa Cruz | | | | |
| Shasta | | | | |
| Sierra | | | | |
| Siskiyou | | | | |
| Solano | | | | |
| Sonoma | | | | |
| Stanislaus | | | | |
| Sutter | | | | |
| Tehama | | | | |
| Trinity | | | | |
| Tulare | | | | |
| Tuolumne | | | | |
| Ventura | | | | |
| Yolo | | | | |
| Yuba | | | | |

5. What percentage of your health plan's physicians are board-certified?

6. What was the physician and hospital compensation in your health plan in 2004 for the Healthy Families Program (for current participating plans only)?

| Compensation | PCP Providers | Specialist Providers | Compensation | Hospitals |
|---|---|---|---|---|
| Capitation | % | % | Capitation | % |
| Fee Schedule | % | % | Fee Schedule | % |
| Salary | % | % | Per Diem | % |
| Combination of the above (explain) | | | Combination of the above (explain) | |

7. Please respond to the following questions and describe the procedures used for delivering health care services.

| **I. Primary Care Provider Assignment** |
|---|
| a) Describe how the plan will meet the contractual requirement to use a fair and equitable method of automatic assignment, which will include the geographic accessibility and language capability of pediatric/adolescent providers in your network, if a member does not select a primary care provider. (See Exhibit A, Item II.G.) |
| b) How often can members change their PCP in one benefit year? Describe the process. |
| **II. Members Access to Services** |
| a) Describe how the plan will implement the contractual requirement to provide information to new members regarding how to access services. (See Exhibit A, Item II.F.1.a. for examples of acceptable approaches.) |
| b) Can HFP female members see an OB/GYN without a referral from a PCP? |
| c) Describe the process for accessing a specialist in the plan. Please address whether specialists are affiliated with specific PCPs or can be accessed by any member or PCP. |
| d) Describe how members can access a provider for urgent care services outside normal ambulatory setting operating hours. (This can include a 24 hour advice line.) |

e) Describe how members can access a provider for emergency care services outside normal ambulatory setting operating hours.

f) Please describe how the plan will comply with the contract requirement that the plan's providers are made aware of the importance of screening for overweight and obese children. (See Exhibit A, Item V.C.3.)

g) Please describe how the plan will comply with the contract requirement to increase applicants' and members' awareness of the health risks associated with being overweight or obese and the importance of good nutrition and physical activity. (See Exhibit A, Item V.C.3.)

## III. Mental Health and Substance Abuse Services

a) How will the plan assess the mental health needs of members?

b) How will the plan assess the needs of members in regards to alcohol use, drug abuse, and tobacco use?

c) Please describe the process for providing alcohol, drug abuse and tobacco prevention services.

d) Specify what, if any, arrangements are made for the provision of services once the maximum alcohol and drug benefit limit is reached.

e) Will the plan contract with a mental health "carve-out" company or will the plan have mental health providers either on staff or on contract? If a "carve-out" behavioral health company is used, what level of supervision and accountability is maintained to make sure that appropriate services are delivered?

f) Will the plan use the substitution of inpatient mental health days for day treatment, outpatient visits, or residential treatment days to provide more than the 20 outpatient visits as authorized in Article 3. of the Program Regulations? If yes, explain the substitution method that is used.

g) To what extent are mental health providers authorized or encouraged to incorporate family members and primary caregivers in the treatment of children with mental health needs?

## IV. Pharmacy Services

a) Please describe the process members use to obtain prescription drugs. Will the plan require the use of a prescription drug card?

b) Will the plan offer a prescription drug mail-order program? If so, briefly describe the program. Include the ability of members to receive maintenance prescription drugs through the mail.

c) Will the plan have a mandatory formulary? Please describe the appeal process for accessing drugs not included on the formulary.

d) Will the plan use a mandatory generic drug substitution policy? Please describe the process for accessing brand name drugs when a generic substitution is available.

## V. Member Cost Sharing

a) Describe the arrangement the plan has with providers to provide for extended payment plans for members utilizing a significant number of health services for which copayments are required.

b) How will the plan implement the federal government's requirement to exempt American Indian and Alaska Native children in HFP from all copayments in the program?

## VI. Member Complaints and Grievances

a) Describe the plan's policies and procedures for the submittal, processing and resolution of members' complaints and grievances. Please include the plan's mechanism for documenting, tracking and ensuring that members' complaints and grievances are acknowledged and responded to within the required timeframes.

b) How will the plan contact members/applicants regarding complaints? (For example, through the use of staff dedicated to members on complaints and grievances.) Include the process for how non-English speaking members are assisted.

## VII. Member Service

a) How will the plan monitor and evaluate call waiting time and the busy or abandonment rates on the customer service phone lines?

b) Describe how the plan will determine if there is sufficient bilingual staff available on the customer service telephone lines to serve members in all the threshold languages.

c) Describe the system that will be used to ensure compliance with the contractual requirement to provide an Identification Card, Provider Directory and Evidence of Coverage booklet to applicants, on behalf of members, no later than the members' effective date of coverage. For currently participating plans: Please attach to the completed fact sheet a copy of a sample internal report used by your plan to track your performance in this area. (See Exhibit A, Item II.F.)

8. Describe any agreements contemplated or in progress between the plan and other parties which may effect the plan's ownership, corporate structure or management during the January 2005 through June 2006 time period (as allowed by State and Federal Law).

9. Describe any restrictions or pending reviews by state (including the Medi-Cal program) or federal authorities for non-compliance with state or federal regulations or contracts for medical services.

This 2005 Health Plan Fact Sheet for the Healthy Families Program must be signed by the person authorized to sign the health plan's contract.

To the best of my knowledge, all statements and data reported by _____ (health plan) in this Health Plan Fact Sheet 2005/2006 for the Healthy Families Program are true and accurate. I understand that all responses to questions included in the Fact Sheet, except items # 8 and # 9, may be included in comparative charts in the Healthy Families Program brochure or other public documents produced by MRMIB.

Signed

_____
Name

_____
Title

_____
Date